

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029059

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 176 Primary Registration District No. 5656 Registrar's No. 12

FILED AUG 5 1963

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gay Parita (Ozark) Mo.</u>		c. CITY OR TOWN <u>Gay Parita</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>		d. STREET ADDRESS (If outside, give location) <u>Ash Grove R.R. #</u>	
3. NAME OF DECEASED (Type or print) <u>Howard William Gotrost</u>		4. DATE OF DEATH <u>7-30-1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Independence Iowa</u>	
13a. FATHER'S NAME <u>Michael Gotrost</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute circulatory failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>15 min.</u>		11. BIRTHPLACE (City and state or country) <u>Independence Iowa</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		14. NAME OF HUSBAND OR WIFE <u>Beatrice Gotrost</u>	
17. INFORMANT <u>Mrs. Beatrice Gotrost</u>		Address <u>Ash Grove R.R. #</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>3:45</u> Month <u>7</u> Day <u>30</u> Year <u>1963</u> a.m. <u>P.M.</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Lawrence, Mo.</u>	
21. I attended the deceased from <u>12-20-60</u> to <u>7-30-63</u> and last saw him alive on <u>7-30-63</u> Death occurred at <u>3:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <u>7-31-63</u>	
22a. SIGNATURE <u>Hugh Baker</u> (Degree or title) <u>D.O.</u>		22b. ADDRESS <u>Miller, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-1-1963</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Valley View</u>	23d. LOCATION (City, town, or county) (State) <u>Council Bluffs Iowa</u>
24. FUNERAL DIRECTOR <u>Monroe-Lemmon</u> ADDRESS <u>Miller Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-1-1963</u>	26. REGISTRAR'S SIGNATURE <u>W. D. Burmy</u>

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1 0550

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed E. R. Leiman

Licensed Embalmer No. 3297

P. O. Address Miller Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.